mays

DERMATOLOGY & COSMETIC CENTER

Minor Consent for Minor

I, _____
parent(s) or guardian(s) name(s)

give permission for my child _____ ____ / ____ / _____ to
patients name patients date of birth

be seen without an adult present and to be able to make medical decisions by themselves. I understand that I as the parent/guardian am fully responsible for the patients account balance and all balances or charges for the date of service is to be paid at the appointment time.

Signature: _____
Parent or Guardian

Date: _____